Date: 01/06/2014 1:18 PM

This application is for the licensure period **July 1, 2014** through **June 30, 2016**.

Please complete the entire application and return it along with a **$12.00 check/money order**

(payable to: South Dakota Department of Public Safety) by June 15 to:

Office of Emergency Medical Services

South Dakota Department of Public Safety

118 West Capitol Avenue

Pierre, South Dakota 57501-2000

It is important that your application is complete. An incomplete application will be returned;

thereby causing a delay in relicensure. Those applications received after June 15 may result in

a period of time that the service would not be licensed and third party reimbursement agencies

may refuse reimbursement for services delivered during this time.

As changes occur in your service for the first and second contact person, please notify this

office as soon as possible. This information will then be updated on our Web Page.

This will keep information flowing to the services in a more timely manner.

Thank you, in advance for your prompt attention. If you would like more information or

clarification, please call the EMS Office at (605) 773-4031.

Ambulance License Number:

Service Name:

Service Address:

City: State: Zip:

Ambulance Service Licensing Application

South Dakota Emergency Medical Services

July 1, 2014-June 30, 2016

Transport Type In State Ground Transport   Licensing Initial License

Ambulance Service Number and Name: _____

Mailing Address _____

Street Address (for shipping via United Postal Service) _____

City _____ State _____ Zip + 4 _____

Business Phone Number for Service _____

Emergency Phone Number to Access Service _____

E-mail Address _____

Person Completing Application _____

Phone Number _____ Fax Number _____

Primary Contact Person for Service _____

Work Phone _____ Home Phone _____

E-Mail Address _____

Secondary Contact Person for Service _____

Work Phone _____ Home Phone _____

E-Mail Address _____

Medical Director's Name _____

Address _____

City _____ State _____ Zip + 4 _____

Work Phone _____ Home Phone _____

Specific Ambulance Service Data

Service Number: [_____]

    1. Ambulance Service is owned and operated by City

    ☐ Other [_____]

2. What is the annual payment to your Medical Director? $ [_____]

3. Level of Service: Medical Transport

   ☐ Advanced Life Support

   ☐ Basic Life Support

4. What are your current charges for ambulance transports?

Loading Fee ALS [_____]

[_____]

Per Loaded Mile Charge [_____]

Loading Fee BLS [_____]

Per Loaded Mile Charge [_____]

Other Charges [_____]

[_____]

5. Do you charge separately for consumable supplies? Yes ☐ No ☐

6. Do you bill Medicare for service to eligible recipients? Yes ☐ No ☐

7. Do you bill Medicaid for service to eligible recipients? Yes ☐ No ☐

8. Do you charge patients the balance of a bill not paid by Medicare, insurance companies, or other 3rd party payers? Yes ☐ No ☐

9. The person responsible for the billing and claims process for your service is:

Name [_____]

Address [_____]

City [_____] State [_____] Zip + 4 [_____]

Work Phone [_____] Home Phone [_____]

Cell Phone [_____]

Service Number: [_____]

Vehicle Information			
Year, Manufacturer	Serial Number	Type (I,II,III)	Current Odometer Reading

Name	EMT Certification / License #	Level: EMT-Basic; EMT; Intermediate; AEMT; NREMT-P; Paramedic	Expiration Date	Street Address	City/State/Zip